

## Respirator Clearance Health History Questionnaire

1. I	Date Dept/Organization						_		
				<b>.</b>		First Name			-
	—— Gender: M			•	, , ,				
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				1111.					
	Your Weigh								
7. <b>`</b>	Your Job Ti	tle:							
8. I	Phone numb	er where	you can be	reached by a	health care	professional who	reviews this que	estionnaire ()	
9. I	Has your en	nployer to	ld you how	to contact th	e health care	e professional wh	o will review thi	s questionnaire? Yes	No
10. 0	Check the ty	ype of res	pirator you	will use (you	can check r	nore than one cat	egory):		
	Ot		half or full			n-cartridge type ourifying, supplied		ed breathing apparatus)	
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	mave you v	vorn a res	pirator? Y	es No	If yes, w	hat type(s):			_
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		2.				or have you smo			
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Part A. Section 2. (c	cont)
4. Do you <u>currently</u> h	nave any of the following symptoms of pulmonary or lung illness?
YesNo	a. Shortness of breath
YesNo	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Yes No	c. Shortness of breath when walking with other people at an ordinary pace on level ground
Yes No	d. Have to stop for breath when walking at your own pace on level ground
Yes No	e. Shortness of breath when washing or dressing yourself
Yes No	f. Shortness of breath that interferes with your job
Yes No	g. Coughing that produces phlegm (thick sputum)
Yes No	h. Coughing that wakes you early in the morning
Yes No	i. Coughing that occurs mostly when you are lying down
Yes No	j. Coughing up blood in the last month
Yes No	k. Wheezing
Yes No	l. Wheezing that interferes with your job
Yes No	m.Chest pain when you breathe deeply
Yes No	n. Any other symptoms that you think may be related to lung problems
	any of the following cardiovascular or heart problems?
YesNo Yes No	a. Heart attack b. Stroke
Yes No	c. Angina
YesNo	d. Heart failure
YesNo	e. Swelling in your legs or feet (not caused by walking
YesNo	f. Heart arrhythmia (irregular heart beat)
YesNo	g. High blood pressure
YesNo	h. Any other heart problem that you've been told about
=	any of the following cardiovascular or heart symptoms?
YesNo	a. Frequent pain or tightness in your chest
YesNo	b. Pain or tightness in your chest during physical activity
YesNo	c. Pain or tightness in your chest that interferes with your job
YesNo	d. In the past two years, have you noticed your heart skipping or missing a beat
YesNo	e. Heartburn or indigestion that is not related to eating
YesNo	f. Any other symptoms that you may think are related to heart or circulation problems
7. Do vou currently ta	ake medication for any of the following problems?
Yes No	a. Breathing or lung problems
Yes No	b. Heart trouble
Yes No	c. Blood pressure
YesNo	d. Seizures (fits)
0 If	
respirator and mov	spirator, have you ever had any of the following problems? (check this question if you've never worn a ve to question 9)
Yes No	a. Eye irritation
Yes No	b. Skin allergies or rashes
Yes No	c. Anxiety
Yes No	d. General weakness or fatigue
YesNo	e. Any other problem that interferes with your use of a respirator
	talk to the health care professional who will review this questionnaire about your answers?
YesNo	

11. Do you currently have any of the following vision problems? Yes No a. Wear contact lenses Yes No b. Wear glasses Yes No c. Color blind Yes No d. Any other eye or vision problem  12. Have you ever had an injury to your ears, including a broken ear drum? Yes No  13. Do you currently have any of the following hearing problems? Yes No a. Difficulty hearing Yes No b. Wear a hearing aid Yes No c. Any other hearing or ear problem  14. Have you ever had a back injury? Yes No  15. Do you currently have any of the following musculoskeletal problems? Yes No  16. Do you currently have any of the following musculoskeletal problems? Yes No  17. De you currently have any of the following musculoskeletal problems? Yes No  18. De you currently have any of the following musculoskeletal problems? Yes No  19. De you currently have any of the following musculoskeletal problems? Yes No  10. De you currently have any of the following musculoskeletal problems? Yes No  11. De you currently fully moving your arms, hands, legs, or feet Yes No  12. Difficulty fully moving your arms or legs Yes No  13. Difficulty fully moving your arms or legs Yes No  14. Difficulty fully moving your head up or down Yes No  15. Difficulty fully moving your head up or down Yes No  16. Difficulty fully moving your head side to side Yes No  17. Difficulty bending at the knees Yes No  18. Difficulty bending at the knees Yes No  19. Difficulty bending at the knees Yes No  10. Difficulty bending at the knees Yes No  11. Have you had any change in your medical status since your last physical examination? Yes No  12. Have you had any change in your medical status since your last physical examination? Yes No  14. Have you had any change in your medical status since your last physical examination? Yes No  16. Do you currently wear a respirator? Yes No  17. Hour a week, etc.  18. Do you experience any health problems when you wear a respirator? Yes No	10. Have you ever los	t vision in either eye? (temporarily or permanently)
Yes No a. Wear contact lenses Yes No b. Wear glasses Yes No c. Color bind Yes No d. Any other eye or vision problem  12. Have you ever had an injury to your ears, including a broken ear drum? Yes No a. Difficulty hearing Yes No a. Difficulty hearing Yes No b. Wear a hearing aid Yes No b. Wear a hearing aid Yes No c. Any other hearing or ear problem  14. Have you ever had a back injury? Yes No  15. Do you currently have any of the following musculoskeletal problems? Yes No  16. Do you currently have any of the following musculoskeletal problems? Yes No  17. Se No  18. Back pain Yes No  19. Difficulty fully moving your arms or legs Yes No  19. Difficulty fully moving your arms or legs Yes No  19. Difficulty fully moving your head up or down Yes No  19. Difficulty fully moving your head side to side Yes No  19. Difficulty fully moving your head side to side Yes No  19. Difficulty bending at the knees Yes No  10. Difficulty bending at the knees Yes No  10. Difficulty guating to the ground Yes No  10. Climbing a flight of stairs or a ladder carrying more than 25 pounds Yes No  10. Any other muscle or skeletal problem that interferes with using a respirator  Part B. Other Questions  11. Have you had any change in your medical status since your last physical examination? Yes No  11. If Yes, please explain:  22. Do you currently wear a respirator? Yes No  16. If Yes, how often? (i.e. 20% of your shift, 1 hour a week, etc.  35. Do you experience any health problems when you wear a respirator? Yes No	11 Do you currently	have any of the following vision problems?
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3. Do you experience any health problems when you wear a respirator? YesNo	If Yes, how of	ften? (i.e. 20% of your shift, 1 hour a week, etc.
<del></del>		
If Yes, please explain:	YesNo	
	If Yes, please	explain:
4. Based on your health status, do you have any questions or concerns about wearing a respirator?		
YesNo	YesNo	
If Yes, please explain:	If Yes, please	explain:
5. Have you ever been in the military? Yes No		r been in the military?
		ou avnoced to higherinal or chemical agents during training or combet?
If Yes, were you exposed to biological or chemical agents during training or combat?	ii i es, were y	ou exposed to biological of elicinical agents during training of combat?

Your Signature	Provider Signature
Printed	Printed
Date	Date

I understand that all information provided in this questionnaire is retained in my confidential medical record. I certify that I have answered the above questions to the best of my abilities. I understand that only information related to my ability to perform the essential functions of my position would ever be released to my employer. All other information is part of my medical record and

used for purposes of improving my overall health.